Montana's 1115 Waiver Proposal
Comments and Responses to Draft Proposal
Dated September 6, 2005

The Montana Department of Public Health and Human Services (DPHHS) received 20 items of correspondence containing comments on the Department's draft 1115 waiver proposal dated September 6, 2005. Commenters included the American Association of Retired Persons, the American Cancer Society, an assisted living facility, a mental health consumer, a representative of a mental health consumer support group, two mental health centers, Mental Health Ombudsman, Mental Health Oversight Advisory Council, the Mental Health Disabilities Board of Visitors, the Montana Advocacy Program, the Montana Children's Initiative Provider Association, the Montana Council of Community Mental Health Centers, the Montana Mental Health Association, the Montana Primary Care Association, the National Alliance for Mental Illness, a nurse, a hospital CEO, a service area authority, and an uninsured Montanan.

Numerous commenters wrote in favor of the waiver proposal. Commenters said the proposal is commendable, fully worthy of support, makes great sense for the State of Montana, a great idea to insure more people. They particularly support the physical health care benefit for adults who have the Mental Health Services Plan (MHSP), support the benefit for children who lose Medicaid coverage, support services for 18 to 20 year olds who have SED, support providing insurance coverage to parents of children who have Medicaid, and support addressing unmet needs.

Most commenters provided multiple comments. Similar comments are grouped and responses are provided for all comments.

We address issues in the order of the three major concept sections of the proposal *(See: III. Outline of Montana's Proposal for a HIFA Waiver, pages 15 and 16 of the September 6, 2005, proposal document.)*

A. Secure Medicaid Funding to Strengthen the State Mental Health Services Plan

Comment A-1: Several commenters question the sufficiency of reimbursement for and the availability of mental health providers, stating the waiver does not address the serious funding shortfalls in MHSP.

Response A-1: The waiver proposal is not designed to address the budget shortfalls MHSP has experienced in the past. The goal of the waiver is to refinance general fund dollars appropriated for MHSP services with Medicaid funds. The Department is aware that the demand for services for individuals with MHSP exceeds the legislative appropriation for the program. The issue will exist with or without the waiver.

Comment A-2: A commenter states there are extensive waiting lists for clients in MHSP, a limited service array, a dramatic increase in admissions to the Montana State Hospital,

and community mental health centers and hospitals continue to offer charitable care to MHSP beneficiaries.

Response A-2: Again, the waiver is not designed to alleviate the funding problems faced by MHSP, but proposes to use state general fund in a different way to allow current MHSP services to be partially funded with Medicaid dollars and to decrease the number of uninsured people in Montana. In total, more funding will be available for MHSP through the implementation of the waiver.

Comment A-3: A commenter expresses concern about a cap on MHSP services and on the number of available slots in the waiver.

Response A-3: The Department must work within the confines of current legislative appropriations, both when defining MHSP services and when estimating the number of people who will be served under the waiver. An analysis of the average number of MHSP-eligible people who received services during State Fiscal Year 2005 shows that 2,257 people received services each month. Because some people with Medicare received MHSP eligibility specifically for pharmacy services who will no longer need MHSP, the Department believes there will be adequate slots to serve those in need. If necessary, the Department will work with CMS and through the legislative process to add funding and additional slots to the waiver for MHSP.

Comment A-4: A commenter encourages the Department to increase the MHSP eligibility income limit to 200 percent of the Federal Poverty Level (FPL) to match the eligibility of chemical dependency services, and asks, if the eligibility is increased, will the waiver prevent changes if it is submitted with an MHSP eligibility limit of 150 percent FPL?

Response A-4: The Department is not planning to increase the MHSP eligibility income limit to 200 percent FPL under the waiver. There is concern that MHSP funding is spread too thin at the current eligibility income level; if the level is increased to 200 percent, there would be an increased need for services without an increase in the appropriation. However, this waiver can be amended if there are changes to eligibility income limits in the future.

The Addictive and Mental Disorders Division (AMDD) completed a biannual listening tour during the fall of 2005. Requests for an increase in the financial eligibility level for MHSP to 200 percent FPL were made in almost every community. Consideration of this change would require a new funding proposal as well as a statutory change. A change to encompass a higher-income population will not be included in the waiver.

Comment A-5: A commenter is concerned about conflict of interest when the mental health centers have responsibility for determining eligibility for individuals with mental illness.

Response A-5: The Department is reviewing financial and clinical eligibility determination processes. Whether the location for determining eligibility remains the

same or is changed, the Department will develop a quality assurance process that will sample records and applications to ensure that only people eligible for MHSP are enrolled.

Comment A-6: A commenter states that individuals with MHSP do not have freedom of choice of providers due to the limitation of having only four mental health centers.

Response A-6: The Department understands the importance and value of freedom of choice for consumers of mental health services. The Department will review options to expand the provider network to permit more choice for consumers, although this Waiver will still restrict *total* freedom of choice under Medicaid.

Comment A-7: A commenter states that none of the four mental health centers have waiting lists now, but in some parts of the state, individuals wait weeks or months for appointments to have eligibility determined or to receive services.

Response A-7: The waiver may not reduce waiting times for MHSP beneficiaries; however, the Department is reviewing all aspects of services offered through MHSP. The Department has received feedback that much of the waiting time is related to psychiatric services that have a shortage of providers statewide.

Comment A-8: A commenter asks if the waiver will increase pharmacy coverage for individuals with SDMI who are enrolled in the waiver.

Response A-8: MHSP beneficiaries who receive services under the waiver will continue to have a pharmacy benefit of up to $425 per month for medications prescribed for the treatment of mental illness.

Comment A-9: A commenter asks if the Surveillance and Utilization Review Section will have oversight of the services provided if MHSP becomes a Medicaid reimbursed service through the waiver.

Response A-9: Medicaid waiver services are included under the scope of the Surveillance Utilization and Review Section of the Department's Quality Assurance Division.

Comment A-10: A commenter expressed concern about individuals being discharged from waiver services who do not use MHSP services for 90 days.

Response A-10: The removal of individuals from waiver slots after 90 days of inactivity was proposed as a means of managing waiting lists that might develop. The Department believes it is important to facilitate access to services as quickly as possible after determination of eligibility and it is concerned that access would be slowed or denied if all available slots were filled, without consideration of the level of service utilization by those in waiver slots.

Comment A-11: A commenter is supportive of maximizing federal revenue to meet state needs, yet concerned over the diminished funding and ultimate dismantling of MHSP. The commenter is also concerned about cost shifting to counties or to another state-funded program that will cover mental health services and the subsequent financial impacts to these agencies.

Response A-11: The Department neither plans nor foresees a dismantling of MHSP. The Department will work to ensure no cost shifting to other entities takes place as a result of the waiver.

Comment A-12: A commenter questions whether the waiver will improve the lives of people living with severe mental illness, and expresses concern that the proposed waiver will limit access to needed services.

Response A-12: Services under the waiver may improve the health of people living with severe mental illness by adding a physical health care benefit and an inpatient hospital benefit to the current mental health benefits. The Department is investigating avenues to expand access to mental health services for MHSP beneficiaries.

Comment A-13: A commenter suggests coordinating efforts with Service Area Authorities and advocacy groups to facilitate inclusion of consumer protections prior to implementation of the waiver.

Response A-13: The Department is required by statute to coordinate with Service Area Authorities before instituting changes and will continue to do so. The Department also includes advocates and other members of the public in all activities, forums, rule changes, and legislation, and will continue to do so.

Comment A-14: A commenter believes the funding for community services will be diminished if reimbursements are based on the number of enrolled individuals using a capitated formula versus the current funding structure of MHSP based on eligibility within geographic regions.

Response A-14: The Department is looking at all options for reimbursement to providers and will involve mental health providers in the final decision. The Department must also work within policies allowable by the Centers for Medicare and Medicaid Services (CMS) under the waiver.

Comment A-15: A commenter expresses concern about whether MHSP enrollees will have full access to the new health care benefit.

Response A-15: The Department wants to ensure access to the new health care benefit. By providing three distinct options to access health care, the Department believes all MHSP enrollees will be able to access health care from an array of providers.

Comment A-16: A commenter fears MHSP services delivered as "charity care" by the community mental health centers may be diminished as the new reimbursement formula is adopted, resulting in an overall reduction in available mental health services.

Response A-16: The Department proposed a change in the reimbursement formula to operate the waiver under the policies and regulations of CMS as MHSP becomes refinanced with Medicaid dollars. The Department's data indicates that 2,200 slots exceeds the average number of people using MHSP services each month. This capacity is not less than the current utilization of MHSP. (See Response A-3.)

Comment A-17: A commenter clarifies that Community Health Centers currently are not eligible for reimbursement for MHSP, yet the Centers see many patients with mental health needs. The commenter would like to see an increase in the role Community Health Centers play in the delivery of mental health and substance abuse services to increase access and better-coordinated primary care and preventive health services for MHSP beneficiaries.

Response A-17: The Department recognizes that the Community Health Centers play a vital role in access to health care in Montana. The Department will review and consider options to expand the provider network to permit more choice by consumers.

Comment A-18: Several commenters expressed concern about the Department's data on MHSP, that the numbers of Montanans with SDMI are underestimated due to chronic under funding and resultant inadequate system capacity and financial disincentives to fully serve clients. The uncounted and unaccounted-for people are flooding the public mental health system at every level, the correctional and other human services systems, and the Montana State Hospital.

Response A-18: The Department contracted with Western Interstate Commission for Higher Education (WICHE) to gather sound data of serious mental illness and serious persistent mental illness in Montana.

Increases in the numbers of individuals in need of mental health treatment have been demonstrated across Montana—not only at the Montana State Hospital and the Department of Corrections, but also within the community mental health system. The Department has been unable to identify a reason for the increase, but believes that stigma reduction has played a major role. Additionally, the improved understanding of mental illness and mental illness with co-occurring substance use disorder has expanded the awareness of and identification of people with mental illness.

Comment A-19: A commenter asked specific questions about MHSP data. How many people with SDMI are in Montana? How many qualify for MHSP-funded services? Are the treatment needs of adults with SDMI who qualify for MHSP different from those who qualify for Medicaid? To what extent are the needs of adults with SDMI who qualify for MHSP being met now?

Response A-19: The Department contracted with WICHE to develop estimates of the prevalence of serious mental illness and serious persistent mental illness in Montana. The estimates will be stratified by poverty level, which will reveal the number of people who qualify for MHSP.

The treatment needs of adults with SDMI do not differ from those who are eligible for Medicaid. The degree to which the treatment needs of the two groups are met differ insofar as individuals eligible for Medicaid have access to inpatient hospital services, have access to primary health care, and have more freedom of choice of providers.

Encounter data submitted by community mental health centers shows that services provided to persons eligible for MHSP exceed contractual payments by up to 300 percent.

Comment A-20: A commenter expresses concern about restricting eligibility by changing the definition of SDMI, which may reduce the number of "eligibles" but will not reduce the number of people in Montana with biological brain disorders. Their access to appropriate services at various stages of the disease process will simply be reduced.

Response A-20: The waiver proposal does not contemplate changing or restricting the definition of severe disabling mental illness.

Comment A-21: A commenter suggests the $15 million per year in additional federal revenue should be fully allocated to adults with SDMI and children with SED to address the existing unmet needs in the public mental health system.

Response A-21: The federal government does not allow buy-out of a state-funded program, per waiver regulations, and has requirements regarding caps on federal spending for Medicaid expansion groups. The federal government also has requirements to cover the uninsured. The additional federal funding achieved under this waiver proposal cannot be directed to only the groups identified by the commenter, and the groups must meet the federal requirements.

Comment A-22: A commenter states the four community hospitals provide millions of dollars of "charity care" each year to adults with SDMI who have MHSP. The waiver proposal includes the provision of $200,000 per year in total Medicaid funding for short-term acute inpatient psychiatric care for adults with SDMI. The additional funding will help, but based on conversations with the community mental health centers and the four community hospital inpatient psychiatric units, $200,000 will fund an estimated 10 percent of the total need for inpatient psychiatric treatment for adults with SDMI who have MHSP.

Response A-22: The Department has no data on the amount of charity care provided to adults who have MHSP by community hospitals; therefore, the Department would have difficulty justifying additional funds for short-term acute inpatient psychiatric care. The

Department would welcome supporting data in order to better plan for reimbursement of these services in the future.

The Department did, in fact, consider increasing the amount of reimbursement to community hospitals, but to do so would result in covering fewer children and adults under the waiver to remain budget neutral. At this time, providing health care coverage to fewer Montanans is not an option as we try to address the needs of the uninsured.

Comment A-23: A commenter states there are significant waiting lists, reduced capacity and overload in almost every mental health facility in the state. (Commenter cites closure of psychiatric unit in Helena, reduced number of inpatient beds in Billings, full inpatient psych units in Billings, Great Falls, Kalispell, and Missoula, waiting lists for case management programs, up to eight months wait for first appointment with psychiatrist, 15 minute psychiatrist appointment once in several months, up to 7 weeks wait for first appointment with therapists, more than 30 person caseload sizes for case management, double the caseload sizes of ten years ago.) Fifty percent of new clients admitted to Montana State Hospital do not have Medicaid and up to 25 percent of the inmates at Montana State Prison have a serious mental illness.

Response A-23: The Department agrees that in some areas of the state, the public mental health system is as described. Serious workforce shortages are documented statewide.

Unfortunately, the waiver is not designed to address the funding shortfalls or the workforce shortages of MHSP. The goal of the waiver is to refinance general fund dollars for MHSP services with Medicaid funds and to provide coverage for uninsured Montanans.

Comment A-24: A commenter states restricting access to services will not make people with serious mental illness go away and will not contain real costs. Restricting access to services will cause an increase in the number of people with mental illness who enter the system at high end points—emergency rooms, the state hospital, and the corrections system—and will perpetuate an overcrowded and compromised mental health treatment system.

Response A-24: The waiver was not designed to address the programmatic shortfalls of MHSP and especially not to further restrict access to services. The goal of the waiver is the refinance the general fund dollars for MHSP with Medicaid funds and to provide coverage for uninsured Montanans.

Comment A-25: A commenter recommends that DPHHS concurrently do the following: Acknowledge a significant level of unmet need for publicly-funded mental health services; commit to contracting with the University of Montana Rural Institute or another entity to measure the number of adults in Montana with SDMI and the number of children with SED; engage with the legislature in an ongoing dialog that focuses incrementally increasing funding levels for the public mental health system.

Response A-25: The Department contracted with WICHE to develop estimates of the prevalence of both serious mental illness and serious persistent mental illness in Montana. The estimates will be stratified by poverty level. The Department is continually in conversations with the Legislative branch, both during regular sessions and during interim periods. Members of the Legislature are aware of the funding shortfalls of the public mental health system in Montana.

Comment A-26: A commenter expresses concern about mental health centers using prescription drug samples for MHSP beneficiaries who exceed their $425 pharmacy benefit each month. The commenter is worried that pharmacy companies may discontinue sample provision to mental health centers.

Response A-26: The Department has no authority over samples provided to mental health centers by pharmaceutical companies and has no information to lead to the conclusion that there would be an adverse relationship between pharmaceutical samples and individuals receiving mental health services through the waiver.

Comment A-27: A commenter asks if a mentally ill adult enrolled in the waiver can move to another location in Montana and remain on the waiver.

Response A-27: An individual who is enrolled in the waiver may move to another location in Montana without losing his or her waiver slot.

Comment A-28: A commenter is concerned there will not be a non-waiver Mental Health Services Plan for individuals who have Medicare or other insurance that does not have a mental health benefit.

Response A-28: The Department will reserve a portion of MHSP funds for individuals who are eligible for MHSP but not eligible for waiver services; that is, MHSP people with Medicare or other health care coverage.

Comment A-29: Commenters are concerned about individuals with SDMI enrolled in the waiver who have extensive pharmaceutical needs and recommend building inflationary increases into the pharmacy benefit over the five year life of the waiver.

Response A-29: The pharmaceutical benefit for individuals covered under the waiver will not be less than is currently available for medications prescribed for the treatment of mental illness. In addition, an individual may elect to use a portion of the primary health care benefit to purchase needed medications above the $425 monthly limit.

Comment A-30: A commenter questions what safeguards are in place for SDMI individuals enrolled in the waiver to ensure they are receiving adequate services for their mental health and physical health needs.

Response A-30: The Department, through the Addictive and Mental Disorders Division, will monitor a sample of eligibility determinations and service deliveries. These quality

assurance checks will assure individuals are receiving appropriate services under the waiver.

Comment A-31: A commenter explained that some individuals with SDMI find their psychiatric symptoms improve when they take medication normally prescribed for a non-psychiatric illness or condition.

Response A-31: The Department understands this situation and will continue the prior-authorization process to review and approve off-label usage for some medications.

Comment A-32: Two commenters expressed concern about the MHSP cap and waiver slots because the state hospital and the state prison system rely on MHSP access for medication and other services for individuals leaving a facility. In addition, slots give contractors little incentive for outreach unless some slots are unfilled. At risk populations (mentally ill) affected when there is little outreach are the homeless and those returning to communities from jail, prison, or the state hospital. This situation may lead to longer stays in jails, prisons, or the state hospital if slots are full.

Response A-32: The Department will continue to coordinate with the state hospital and the corrections systems to assure entry into MHSP for appropriate individuals. Services will be delivered according to priority. The Department welcomes additional options for coordination and service delivery to these populations.

Comment A-33: A commenter asks what options an individual with MHSP has to receive coverage and response to a crisis.

Response A-33: Crisis response may vary according to an MHSP enrollee's community. Community resources are mobilized to the best of each community's abilities.

Comment A-34: A commenter notes that some MHSP enrollees "spend down" into Medicaid intermittently for various periods of time and asks about the ease of returning to their MHSP waiver slot when the individual no longer qualifies for Medicaid.

Response A-34: The Department will consider this population when defining who will be served with waiver funds and who will be served with general fund dollars. The waiver proposal does not eliminate services for this population.

Comment A-35: Two commenters note that the waiver proposal allocates nearly $1.3 million per year additional Medicaid funding for MHSP and asks if the increase can be used to pay for services already provided but not billed by contractors (four mental health centers). Also, the waiver proposal includes a short-term psychiatric inpatient benefit and they question why this benefit was chosen over coverage for crisis services in the emergency room or in a non-inpatient setting, which would help the Department discover if inpatient coverage in the community reduces admissions to the State Hospital.

Response A-35: The Department has not yet finalized the plan of benefits for waiver services. The Department is considering the use of the additional funding for services such as an increase in the limit for the drug benefit, crisis stabilization, or PACT.

Comment A-36: A commenter expresses concern that some of the current expensive MHSP services such as adult group home and foster care, crisis stabilization, and PACT may be at risk for reduction or elimination if the cost of services or drugs increase beyond the agreed upon growth rate in the waiver.

Response A-36: The Department shares the concern of the commenter about rising costs of prescription drugs for the treatment of mental illness but utilizes all possible avenues to contain costs, such as joining a purchasing pool with other states, realizing rebates from manufacturers, and exploring preferred drug lists when feasible. The costs of other services are negotiated on an annual basis and the Department does not foresee reducing or eliminating these services under the waiver.

Comment A-37: A commenter noted that the annual maximum limit of $200 for prescription drugs is particularly inadequate for a population of seriously mentally ill adults.

Response A-37: The waiver does not limit prescription drugs to $200 a year. The $200 figure noted in Attachment F (page 53) of the waiver proposal is the minimum benefit that private insurance can offer if a waiver beneficiary uses his or her benefit to purchase private insurance. Adults with SDMI who are enrolled in MHSP will continue to receive the current $425 monthly benefit for prescription drugs for the treatment of mental illness and can use some or all of their waiver benefit for an additional prescription drug benefit.

Comment A-38: A commenter noted the waiver proposal does not offer a choice of providers for mental health care, yet offers choices for physical health care. The commenter recommends offering a choice for mental health services from any willing provider.

Response A-38: The Department will consider options for expanding the number of mental health service providers. However, the waiver proposal will not expand access to any willing provider and will in fact request waiver of the freedom of choice of providers under Section 1902 of the Act.

Comment A-39: A commenter states that more risk analysis of the Mental Health Services Plan is necessary.

Response A-39: The Department does not anticipate that the waiver will put MHSP at additional risk. The waiver proposal was not designed to address current MHSP deficiencies.

Comment A-40: A commenter is concerned that individuals with mental illness who are put on the waiver waiting list will be unable to access pharmacy services until a waiver slot becomes available.

Response A-40: The Department agrees, and is willing to consider the possibility of providing a state-funded pharmacy benefit for people eligible for MHSP who are on a waiting list.

Comment A-41: A commenter expresses support for continuing MHSP as it currently exists, with a cap on funding rather than a cap on the number of enrollees, to allow contractors flexibility to provide services to an eligible person with urgent needs. Another commenter notes all eligible applicants are enrolled now, but when the mental health center contractors run out of contract dollars, they reduce services provided to individuals with MHSP. A third commenter recommends the Department create enrollment criteria for MHSP individuals entering the waiver, defining who is "in" and avoid "lock-out" of mentally ill individuals with greater needs.

Response A-41: The Department recognizes the importance of providers' ability to treat enrollees with urgent needs. Crisis stabilization, emergency treatment, and access to immediate care are being considered outside of waiver services.

Comment A-42: A commenter recommends the Department evaluate the four mental health centers' current MHSP enrollees to ensure people are receiving adequate care, that eligibility determination is performed according to rules and policies, and if there is adverse selection of mentally ill adults because of funding shortages and the needs for extensive services. The Department should also survey MHSP beneficiaries for overall satisfaction of the program.

Response A-42: A component of the waiver is the establishment of an oversight function that will address the commenter's concerns. The Department agrees that MHSP beneficiaries should be surveyed for satisfaction of the program and services provided, and has in fact conducted surveys of MHSP beneficiaries.

Comment A-43: A commenter notes that individuals who are SDMI have a tremendous unmet need for mental health services and expressed a concern that a cap on the number of waiver enrollees and subsequent waiting list will make the situation worse.

Response A-43: The Department agrees there is unmet mental health needs in Montana but does not anticipate that introduction of the waiver will worsen the situation.

B. Provide Medicaid Funded Health Care Coverage for Low Income Uninsured Montanans

Comment B-1: A commenter expresses concern about minimal Medicaid insurance for an optional population.

Response B-1: Medicaid waivers allow states, with permission from the federal government, to provide benefits and services that are not as comprehensive as those available to mandatory Medicaid populations. The groups that will receive health care coverage under the waiver are currently without health insurance. The coverage that will be offered under the waiver is not optimum but is better than having no coverage, which is the current situation for many MHSP eligible people.

Comment B-2: A commenter questions the possibility of the optional and expansion populations' ability to change coverage and benefits mid-year.

Response B-2: The Department has not yet defined the details of the programs outlined in the waiver but foresees that standard health insurance provisions would apply for coverage obtained through health insurance companies, for example, changing during the annual change period or as a result of a life-changing event.

Comment B-3: A commenter states the calculation on page 38 of the waiver proposal that uses 3% to 4% as the amount of inflation for cost estimates is too low, and that a low estimate will result in benefit cuts in the future. The commenter would assume 9% for medical cost inflation is more reasonable.

Response B-3: The Department will review current trends before finalizing the cost estimates. Using unnecessarily high estimates will result in fewer people receiving benefits than available funds allow. Health care inflation is high but the Department chose to be conservative in the estimate and make adjustments as necessary.

Comment B-4: A commenter expresses concern that the $200 limit for prescription drugs seems low, especially for a person with cancer.

Response B-4: The Department agrees that a $200 annual pharmacy benefit is low. However, $200 pharmacy benefit is the lowest amount a private insurance plan can contain and still be eligible for purchase by waiver participants. The pharmacy benefit, combined with additional services, must be equivalent to or exceed the minimum benefits listed in the table on page 53 of the waiver draft document.

Comment B-5: A commenter expresses concern about waiving EPSDT requirements for screenings to identify physical and mental conditions.

Response B-5: Children eligible for Medicaid will continue to receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Under the waiver, if children are determined eligible for CHIP and there are no CHIP slots available, the children will receive a CHIP-like benefit funded by Medicaid.

Comment B-6: A commenter states that Federally Qualified Health Centers (FQHCs) provide care for Montana Medicaid recipients and uninsured individuals and suggest language should be added to the proposal acknowledging this critical role and supporting continuation of the federally mandated Medicaid prospective payment rate for FQHCs.

Response B-6: The Department agrees.

Comment B-7: A commenter suggests the waiver contain enrollment and administrative processes that are easy to implement and understand, and that the provision of outreach services should be increased to help potential and current beneficiaries navigate the system. The commenter states that Community Health Centers can provide an option for outreach and enrollment assistance to these new populations.

Response B-7: The Department agrees there is a need for quality outreach and support services to assist beneficiaries in navigating the system. Benefit coordination is a component of MHSP waiver services. The Department will review and consider options to expand the outreach and enrollment network to uninsured Montanans who will be eligible for heath care services.

Comment B-8: A commenter notes that the current CHIP benefit may not meet the needs of a child with SED and understands there are plans to add an "MHSP-type" benefit back into CHIP.

Response B-8: The Department added an additional mental health benefit for children enrolled in CHIP who have SED, effective March 1, 2006. An identical benefit will also be available to the optional waiver population of former youths with SED who are transitioning from foster care. The Department will include the new CHIP-like mental health benefit change in the final waiver proposal. However, the increased costs for this additional benefit will impact the number of Montanans that can be covered under the waiver.

Comment B-9: A commenter who has participated in many discussions on the unmet needs of transition-age youths, 18 to 21 years old, who have SED diagnoses that do not translate to SDMI, would like to see an expansion of this program if the need exists and resources are available.

Response B-9: The Department agrees and will monitor the success of the services for this population included in the waiver proposal.

C. Secure Medicaid Funding to Strengthen the MCHA Premium Assistance Program

Comment C-1: A commenter appreciates the Medicaid premium assistance pilot program by funding the Montana Comprehensive Health Association (MCHA) with Medicaid to cover up to 160 individuals and provide premium assistance and incentive payments to cover up to another 1,200 uninsured working parents under the small business insurance pool created under House Bill 667.

D. General Comments

Comment D-1: Two commenters said there are too many patients in the Montana State Hospital and would like the Department to evaluate the possibility of patients being discharged to a community setting.

Response D-1: Patients at Montana State Hospital are evaluated for treatment needs and discharge readiness on a continual basis. The median length of stay for persons discharged from involuntary civil commitments in 2005 was 63 days. Many of the longer-term patients at Montana State Hospital are on forensic commitments and in most circumstances, approval for discharge requires authorization by a Montana District Court.

Comment D-2: A commenter wants to know if there have been refusals of mental health centers to provide care to discharged patients from the Montana State Hospital due to the cost of services and lack of contract funding.

Response D-2: Pre-discharge evaluation of aftercare needs includes a determination of financial eligibility for publicly funded mental health services in the community. Some individuals require a very high level of aftercare services that can be very expensive to provide. A variety of funding barriers may exist. The Department regularly engages in planning processes to evaluate system needs, establish priorities, and make the best use of public funds. Finding funding sources for aftercare services needed by persons discharged from Montana State Hospital can be challenging but is a fundamental aspect of discharge planning. At times, there are some services that cannot be provided because of lack of funding sources, but alternative plans are developed and implemented. There is no evidence that funding barriers for community services are a primary reason why some individuals remain hospitalized for extended periods.

Comment D-3: A commenter asks if providers are required to accept huge discounts and rules of excess regulation.

Response D-3: The Department developed the 1115 Medicaid Waiver Concept Paper without a requirement for providers to accept discounts and without rules of excess regulation. Payers will negotiate with providers for reimbursement amounts.

The Department will file administrative rules when the federal government approves the waiver. Providers and the general public will have the opportunity to submit comments and attend the public hearing at that time.

Comment D-4: Several commenters asked if the Department would increase copayment amounts or decrease the quality and quantity of services for individuals with regular Medicaid to finance the 1115 waiver.

Response D-4: The Department will not increase cost-sharing requirements or decrease the quality or quantity of services for individuals with regular Medicaid to finance the 1115 waiver.

Comment D-5: A commenter requests that everything possible be done to ensure that early medical care is provided for pregnant women to prevent costly complications and decrease the chances of low birth weight babies or pre-term babies.

Response D-5: The Department shares the concern that pregnant women receive early medical care. Pregnant women may be part of one or more of the eligibility groups under the waiver and will be encouraged to seek early medical care. In addition, the Department will coordinate waiver eligibility with State Plan Medicaid eligibility for any person meeting the pregnant woman eligibility requirements.

Comment D-6: A commenter who is a small business owner asks if the waiver will affect the Home and Community Based Services Waiver that providers care for elderly and disabled individuals so they don't have to go to nursing homes.

Response D-6: The waiver will have no effect on the Home and Community Based Services Waiver services for elderly and disabled individuals.

Comment D-7: A commenter asks if the waiver will affect the prospective payment reimbursement to Federally Qualified Health Centers under Medicaid.

Response D-7: The waiver will not affect the prospective payment reimbursement to Federally Qualified Health Centers.

Comment D-8: A commenter asks if the Department is considering self-administering the Children's Health Insurance Plan (CHIP) as a cost-containment measure.

Response D-8: The 2005 Legislature changed the CHIP statute to allow the Department to administer the Children's Health Insurance Plan. As of February 2006, the Department is analyzing options, which include continuing to purchase insurance for CHIP enrollees, contracting with a third-party administrator, or administration by the Department.

Comment D-9: A commenter requests the Department to seek a favorable outcome in the negotiation process with the federal government that reflects the principles, goals, and strategies outlined in this proposal, and states that the public needs to be kept informed of the process.

Response D-9: The Department is committed to a favorable outcome in the negotiation process and will not move forward with a proposal that jeopardizes the existing Medicaid program. The Department's website will include all correspondence to and from the Centers for Medicare and Medicaid Services.

Comment D-10: Three commenters believe it essential that the Department establishes systems that will provide baseline data, measure outcomes, monitor the effects of the waiver on the availability of community services, inform policy makers about changes to

services and utilization, and recommend improvements for the effectiveness of the project.

Response D-10: The Department agrees and will include mechanisms to monitor and evaluate the implementation of the waiver and measure baseline data and outcomes.